Distraction and Nonpharmacologic Techniques for Pain Management
New Approaches to Pain: Exploring Nonpharmacologic, Child Life & Distraction Toolbox Techniques for Pain Management in Emergency and Acute Care Settings

Inaugural Pilot Course - April 21st 2017
Jacksonville, FL

Introductions and Housekeeping

- Materials
- Link on website
- Toolboxes
- Restrooms, parking, Wi-Fi
- CEUs and CMEs
- Feedback, group and individual evaluations, and ideas
- Door prizes
- Name this course

DISCLOSURES

Course includes materials from the Pain Assessment and Management Initiative (PAMI), a free access educational project. Funding provided by Florida Medical Malpractice Joint Underwriting Association, Alvin E. Smith Safety of Health Care Services Grant 2014-2018.

Contact Information

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For more information visit http://pami.emergency.med.jax.ufl.edu/
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- Colleen Kalynych, MSH, EdD
- Raina Davidman, LPN, EMT, MBA
- Danielle Hernandez, BS, CCLS, CTRS
- Audience

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- Taylor Miller, BS
- James Sierakowski, MPH, DO
- Laura Mitchell, CCLS
- Leigh Driskill
- UF Health Pediatric ED & Trauma Center

...and the children and parents we serve!

Sponsors and Collaborators

- FMMJUA
- University of Florida College of Medicine-Jacksonville
  - Department of Emergency Medicine
- Suwannee River AHEC
- TraumaOne Flight Services
- Numerous state organizations

Stakeholders and Collaborators

- EMS for Children Program

Learning Objectives

- Describe safety aspects of pain management and the need for a stepwise approach to pediatric pain management and sedation in emergency and acute care settings.
- Describe advantages of using nonpharmacologic pain management techniques to decrease opioid use, save time, and improve patient safety.
- Discuss how developmental stage, cognitive impairment, genetics, and past pain experiences influence the approach to pain management.
- Discuss nonpharmacologic techniques and child life concepts for managing painful or anxiety provoking procedures and conditions including distraction, imagery, comfort positions and others.
- Explain components and ways to develop and fund a “Distraction Toolbox” appropriate for EMS, ED, and hospital settings and different ages.
- Determine child life, hospital and community resources that can be incorporated into an ED/EMS pain management initiative.

Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>8:30-9:00</td>
<td>Registration</td>
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<tr>
<td>9:00-10:00</td>
<td>Basics of ED and EMS Pain Management</td>
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<tr>
<td></td>
<td>● Opening Pediatric and Adolescent Case Scenarios</td>
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<td></td>
<td>● Background of Pain Management in ED and EMS</td>
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<td></td>
<td>● PAMI Stepwise Approach to Pain Management</td>
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<td>● Responses to Pain by Developmental Stage</td>
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<td></td>
<td>● Overview of Pharmacologic Pain Management</td>
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<td></td>
<td>● Question &amp; Answer</td>
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<td>10:00-11:00</td>
<td>Nonpharmacologic Pain Management</td>
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<td></td>
<td>● Conversation and Therapeutic Language</td>
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<td>● Coaching and Preparation</td>
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<td>● Psychological and Cognitive Behavioral</td>
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<tr>
<td>11:00-11:15</td>
<td>Break and Distribution of Distraction Toolboxes</td>
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<tr>
<td>11:15-12:15</td>
<td>Putting It All Together-Program Implementation</td>
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<td></td>
<td>● Educational Resources, Supplies and Videos</td>
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<td></td>
<td>● Implementation in your Community</td>
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<td>● EMS Week May 2017</td>
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<td>● Community Resources and Networking Opportunities</td>
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<td></td>
<td>● Feedback and Questions</td>
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<tr>
<td></td>
<td>● Name This Course</td>
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</tbody>
</table>

Interventions

- Physical Sensory Interventions
- Distraction Toolbox Development
- Educational Resources, Supplies and Videos Implementation in your Community
- EMS Week May 2017
- Community Resources and Networking Opportunities
- Feedback and Questions
- Name This Course
Basics of ED and EMS Pain Management: Part 1

- Opening Case Scenarios
- Background of Pain Management in ED and EMS
- PAMI Stepwise Approach to Pain Management
- Responses to Pain by Developmental Stage
- Overview of Pharmacologic Pain Management
- Question & Answer

Case Scenarios To Ponder

Case Scenario: Head Trauma & Laceration
Rescue is called to the house of a 4 year old boy who cut his forehead after a fall while running. He had a brief LOC. Initially the boy was calmly sitting in his mother’s lap but now begins to cry, throws his toy truck at the paramedic’s face. Blood is dripping down his face. His mother is crying and asks if you will “report her”.

What can be done to help calm the child and mother in order to perform further evaluation of the injury?

Case Scenario: Laceration continued
Upon arrival to the ED they are greeted by the treatment “team”. The ED physician comments, “That cut is pretty deep. It’s going to need stitches. Don’t worry, it will only hurt a little. You won’t remember any of it after we put you to sleep”. He tells the nurse to start an IV and leaves the area.

Is the physician’s language developmentally-sensitive?  
What unintended consequences may occur?  
What pharmacologic and nonpharmacologic treatment options could be used in this case?

Case Scenario: Burn
- A 6 foot, 200 pound 18 year old with cerebral palsy and development delay was burned by boiling water. He is now crying and thrashing with obvious full-thickness burns to chest, arms, and hands.
- A 2 year old pulled a pot of boiling water and pasta off the stove. She has burns on her arms, chest and face. She is screaming and running away from you- at the scene, in the ED.

Would you handle these two cases the same?

Case Scenario: Car Crash
- On a rainy Saturday night, a father of 3 loses control of his car at 50 mph. Roll over with mother, father and 3 children in the car. Family is driving home after a trip to Disney. Everyone is awake and screaming when you arrive. Primary survey good but….blood, glass, deformed extremities, tachycardia, pain and anxiety!

How can you differentiate tachycardia from pain and anxiety versus shock or cardiorespiratory compromise?
Case Scenario: Past History

- 5 year old female with obviously deformed forearm S/P fall off playground equipment arrives via EMS from school. She is crying hysterically and saying “Please don’t tell my momma I was a bad girl”. Father arrives ten minutes later and appears quiet and exhausted. ED/EMS staff is concerned that he doesn’t seem to be doing anything to comfort his daughter. You ask if he has notified the child’s mother of the accident. The child’s eyes light up but he shakes his head. Finally you ask why he has not called the girl’s mother; he responds “She died 3 months ago”…

_How do past experiences influence responses to pain and traumatic events?_

Why: Course History and Need

- Pain is the most common reason for seeking health care and as a presenting complaint accounts for up to 78% of ED visits; 50% of EMS runs.
- Chronic pain alone affects more Americans than diabetes, cancer, and heart disease combined
- Painful or anxiety provoking procedures are often necessary
- Untreated pain and anxiety can have long term effects

Why: Course History and Need

- Majority of emergency care providers (physicians, nurses, advanced practitioners, and paramedics) are not trained in nonpharmacologic means of managing pain and anxiety
- Limited pain education in professional health related schools
- Most EDs do not have child life specialists, psychologists, or other resources to assist patients in pain or during procedures
- 80% of US children are seen in general EDs

Examples

- Fracture reduction & orthopedic procedures
- Burns
- Multiple trauma transport
- Planned endoscopy or bronchoscopy
- IV or blood draw
- Lumbar puncture
- Chest tube insertion
- Radiographic studies in agitated or uncooperative patients
- Abscess I & D
- Laceration repair
- Sickle Cell Pain Crisis
- Foreign body removal

Other Settings In Addition to ED/EMS

- Hospital
- Clinics
- Outpatient procedures
- Dentist office
- Sedation services and pain clinics or consultations
- Hospice
- Controlled vs uncontrolled
- Planned vs unplanned
- Basis for experience, knowledge, research, etc.
**Why Aren’t We Managing Children’s Pain? NY Times April 2016**

One of the best ways to address the epidemic of chronic pain in this country is to stop it before it starts. If we could reduce painful experiences in childhood we might be able to reduce chronic pain in the next generation. Drafting training in pain management is scant. Veterinary schools require “at least five times more education on how to handle pain” than medical schools, Nora D. Volkow, the director of the National Institute on Drug Abuse, said earlier this year in testimony before a Senate committee.

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**Pain in the ED and EMS Settings**

- Pain is often undertreated especially in children, women, African-Americans, and Hispanics.
- Only half experience pain relief prior to ED arrival.
- PECARN studies: trauma accounts for 28% of pediatric EMS calls but <1% received pain medications.
- Pediatric prehospital pain management listed in top ten research priorities for PEM.

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**Basic Tenants of Pain Management**

- Pain and anxiety are twins.
- Different types of pain require different approaches.
- Treat pain like any other abnormal VS or disease.
- Actions of ED and EMS providers:
  - Set the tone for the entire hospital experience.
  - Affect reaction to future painful experiences.

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**Why EMS & ED Pain Management?**

- Significantly decreases waiting times for pain reduction or relief.
- Pre-hospital pain management aids in improved ED triage, patient comfort, vital signs, and patient assessment.
  - Trauma patient example with tachycardia- shock vs. pain.
- Early management provides long-term benefits:
  - Decreased long-term sequela of children.
  - Prevention of chronic pain through the development of hypersensitized pain pathways.
  - Uncontrolled acute pain may have a link to PTSD and if inadequately treated can lead to chronic pain.
  - Prevents reduced response to appropriate analgesia dosages.

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**Pain: Background**

- Total upheaval in the world of pain management.
  - New research regarding the neurobiological complexity of pain and long term consequences of untreated acute pain.
  - Seeing different types of pain due to MVCs and distracted driving, sports, technology,…
  - New methods of treating pain:
    - Post op nerve blocks.
    - Focus on discharge and readmits.
    - Growth of pain specialists and procedures.

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**Pain: Background**

- Opioid addiction epidemic has everyone pointing fingers and outcry for reducing opioids.
  - CDC, The Joint Commission, HCHAPS survey scoring.
  - “Blame Game”
  - Focus shifting to adolescents and adults that abuse the system versus those in real pain- how to balance?
- State prescription drug monitoring programs.
- Pain MCI.
Patient Safety Aspects: ED/EMS Challenges

- Crowded and high risk environment with pressure to see patients rapidly
- Responsible for diagnosis and management of hundreds of different disease states and injuries from a premature infant to a ninety year old.
- Lack of pre-existing relationships or knowledge of past medical and medication history.
- See a unique population of patients often with mental illness, substance abuse, and co-morbidities leading to biases and burnout.

Pain 101

Classification of Pain

Pain is broadly classified by underlying etiology, anatomic location, the temporal nature, and intensity.

- **Underlying etiology** refers to the source of the experienced pain.
- **Anatomic location** refers to the site of pain within the body and can divided into somatic and visceral.
- **Temporal nature** refers to the duration of the pain.
- **Intensity** refers to how the pain experience hurts.

Factors Affecting Patient Response to Painful Stimuli

- Age, gender, ethnicity
- Socioeconomic and psychiatric factors
- Culture and religion
- Genetics
- Previous experiences
- Patient perceptions
- Patient expectations and perceived care by the treating provider(s)
Physiologic and Psychologic Effects

- Pain can cause
  - tachycardia,
  - hypertension
  - increased myocardial oxygen consumption
- Abnormal vital signs in the presence of pain may be misconstrued as another disease process or lead to an incorrect assessment or treatment
- Be cautious in using vital sign abnormalities as a sole indicator—patients can still be in a great deal of pain with normal vital signs
- Look for subtle clues: facial grimacing, patient position

Pain Assessment Tools: OPQRST, SOCRATES, etc.

The OPQRST-ASP method can be utilized to help with initial patient assessment with input from child and caregiver.

- **O**: Onset (when did it start)
- **P**: Provocation or Palliation (what makes it better or worse)
- **Q**: Quality (sharp, dull, crushing)
- **R**: Region and Radiation
- **S**: Severity (pain score)
- **T**: Timing (type of onset, intermittent, constant)
- **AS**: Associated Symptoms
- **PN**: Pertinent Negatives

Pain Assessment Scales

- Adult
- Pediatric
- Special Situations
- Sedation scales

Examples of Pain Scales

<table>
<thead>
<tr>
<th>Pain Scales</th>
<th>Verbal, Alert and Oriented</th>
<th>Non-verbal, GCS &lt;15 or Cognitive Impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>1. Verbal Numeric Scale (VNS) / Numeric Rating Scale (NRS)</td>
<td>1. Adult Non-Verbal Pain Scale (NVPS)</td>
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<td></td>
<td>2. Visual Analog Scale (VAS)</td>
<td>2. Assessment of Discomfort in Dementias (ADD)</td>
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<td></td>
<td>3. Defense and Veteran Pain Rating Scale (DVPRS)</td>
<td>3. Behavioral Pain Scale (BPS)</td>
</tr>
<tr>
<td>Pediatric</td>
<td>4. Critical Care Observation Tool (CPOT)</td>
<td></td>
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<tr>
<td></td>
<td>Birth – 6 mos</td>
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<tr>
<td>3 yo and older</td>
<td>1. Wong Baker Faces</td>
<td>1. Neonatal Infant Pain Scale (NIPS)</td>
</tr>
<tr>
<td></td>
<td>2. Oucher (3-12 yrs)</td>
<td>2. Neonatal Pain Assessment and Sedation Scale (NPASS)</td>
</tr>
<tr>
<td>8 yo and older</td>
<td>4. FLACC</td>
<td>4. CRIES</td>
</tr>
<tr>
<td>Infant and older</td>
<td>1. Revised Faces, Legs, Activity, Cry, and Consolability (r-FLACC)</td>
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<tr>
<td></td>
<td>2. Non-Communicating Children’s Pain Checklist (NB-CP-C)</td>
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<td></td>
<td>3. Children’s Hospital of Eastern Ontario Pain Scale (CHEOPS) (ages 1-7)</td>
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</tbody>
</table>

Pain Assessment Scales

- No pain scale validated for pre-hospital use
- Most pediatric pain scales were originally developed to measure procedural-related pain.

Categories:
- Observational-behavioral scales require provider to assess patient on multiple behaviors and rank them.
- Self-report scales include selection of a face or color or number to represent pain.

FLACC Scale

- No particular expression or sounds.
- Onset of rapid or slow, shallow or deep breathing
- Preparing to attempt intubation, movement or other invasive procedures
- Preparing to inject pain medication
- Preparing to use pain medication
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- Preparing to use pain medication
Overview of PAMI Stepwise Approach to Pain
(Adapted to Setting- ED, Hospital, EMS)
Ideal approach not always possible

Step 1: Determine the Situation: What are you trying to accomplish or manage?

- Pain only
- Pain and anxiety or agitation
- Anxiety only
- Agitation only
- Procedure that will induce pain or anxiety- transport, IV, ..........umbrella
- Chronic pain condition exacerbation

Determination accomplished after brief triage, history, exam

Responses to Pain by Age or Development

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Understanding of Pain</th>
<th>Behavioral Response</th>
<th>Verbal Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school</td>
<td>Pain is a fact- may relate cause or history; pain modifies behavior; may relate to injury; may relate to pain; use pain as a coping mechanism; may continue to report pain even when no longer in pain; reports pain</td>
<td>Pain is a fact- may relate cause or history; pain modifies behavior; may relate to injury; may relate to pain; use pain as a coping mechanism; may continue to report pain even when no longer in pain; reports pain</td>
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<td>School Age Children</td>
<td>Pain is a fact- may relate cause or history; pain modifies behavior; may relate to injury; may relate to pain; use pain as a coping mechanism; may continue to report pain even when no longer in pain; reports pain</td>
<td>Pain is a fact- may relate cause or history; pain modifies behavior; may relate to injury; may relate to pain; use pain as a coping mechanism; may continue to report pain even when no longer in pain; reports pain</td>
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<td>Teens</td>
<td>Pain is a fact- may relate cause or history; pain modifies behavior; may relate to injury; may relate to pain; use pain as a coping mechanism; may continue to report pain even when no longer in pain; reports pain</td>
<td>Pain is a fact- may relate cause or history; pain modifies behavior; may relate to injury; may relate to pain; use pain as a coping mechanism; may continue to report pain even when no longer in pain; reports pain</td>
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Step 2: Perform a Developmental Checkpoint

- What is the developmental stage of patient?
- Is development normal for age?
- Developmental delay
- Special health care needs
- Mental health concerns
- Recent traumatic events
- Regression to lower developmental stage

What are characteristics of developmental stage in response to pain?
How do you adapt your approach based on developmental level?

Pain Management: Putting it All Together
- No Perfect Recipe or “Cookbook”
- No Universal Kid Recipe

Kids and teens don’t always follow the charts!
How do you adapt your approach based on developmental level?
### Perform Behavioral Observation in an Infant

When performing an infant behavioral observation, be aware of:
- Facial expressions
- Extremity activity and tone
- Guarding, splinting
- Position and tone
- Irritability, crying
- Poor feeding
- Poor sleep quality

#### Facial Expression
- Bulged brow
- Tightly shut eyes
- Nasolabial furrow
- Stretched mouth
- Taut tongue

### Perform Behavioral Observation in a Toddler

When performing a toddler behavioral observation, be aware of:
- Anger
- Tantrums, regression
- Facial expression
- Extremity activity and tone
- Guarding, splinting
- Position of comfort
- Irritability, crying
- Poor eating and sleep quality
- Restless or unusually quiet

### Perform Behavioral Observation in a Preschooler

When performing a preschooler behavioral observation, be aware of:
- Stalling/delaying
- Magical thinking explanations
- Behavioral regression
- Facial expression, grimacing
- Extremity activity and tone
- Guarding, splinting
- Position of comfort
- Irritability, anxiety
- Change in appetite or sleep quality

### Perform Behavioral Observation in a School-age and Adolescent

When performing a school-age and adolescent behavioral observation, be aware of:
- Stalling/delaying
- Flat affect
- Facial expression
- Extremity activity and tone
- Guarding, splinting
- Position of comfort
- Irritability, anxiety
- Change in appetite or sleep quality

### Table: Understanding of Pain and Behavioral Response by Age Group

<table>
<thead>
<tr>
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<th>Understanding of Pain</th>
<th>Behavioral Response</th>
<th>Verbal Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toddlers</td>
<td>1–3 years Doesn't understand what causes pain and why they might be experiencing it</td>
<td>Localized withdrawal, resistance of entire body, aggressive behavior, disturbed sleep</td>
<td>Cries and screams, can't describe intensity/type of pain; Use words for pain such as owie and boo-boo</td>
</tr>
</tbody>
</table>

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**Learn How to Observe Pain by Developmental Stage**

- **Infant**
  - [Image]
- **Toddler**
  - [Image]
- **Preschooler**
  - [Image]
- **School-age and Adolescent**
  - [Image]
**Step 3: Family Dynamic Checkpoint**

- Who is with the child?- parents, siblings…
- Who is the legal guardian?
- Who actually cares for the child?
- Who do you want to deal with?
- Culture, past experience
- What can they tolerate
- Other priorities- another injured child, etc.
- Family personality and stress level

**Step 4: Facility (Agency/Community) Checkpoint**

- Staffing and setting
  - Community, rural, children’s hospital
- Experience
  - Pediatric
- Team capabilities and expertise
- Existing hospital/agency policies
- Acuity and overcrowding of the ED
- Other priorities- MCI, etc.
- Equipment, monitoring, backup

**Step 5: Patient Assessment Checkpoint**

- Review history, assessment and risk factors
- Chronic illness-previous painful experiences, recent surgery
- Psychiatric and mental considerations
- Injury severity, +/- contraindications to opioids or sedation
- Body habitus
  - Weight- ideal or real? Obesity?

**High Risk Considerations**

- History of sleep apnea, adverse events during surgery or anesthesia
- Congenital or genetic airway, facial and lung disorders- Down syndrome, Goldenhar syndrome, etc.
- CSHCN, Technology dependent children
- Post tonsillectomy and adenoidectomy
- Calls to a dentist office

**Step 6: Management Checkpoint: Choose Your “Recipe”**

- No magic recipe, must individualize and adjust “ingredients”
- Pharmacologic “ingredients”
  - Route: oral, nasal, IV, nebulized, topical, nerve blocks
  - Type: sucrose, NSAID, opioids, anxiolytics, ketamine
- Nonpharmacologic “ingredients”
  - Everyone needs a little child life 101- distraction, music, swaddling
  - Engage caregivers and parents- coaching, therapeutic language
  - Will pain duration be short (removal of FB, laceration repair) or prolonged (burn)?

**New Emphasis on Nonpharmacologic Methods of Treating Pain in the ED**

**Painting Analogy**

Think of nonpharmacologic management as your “base coat” or “primer” before applying additional coats of analgesic treatment. With the right base coat foundation, you have a better chance of painting a patient’s symptoms a more tolerable and long-lasting new color.

(PEM Playbook: http://pemplaybook.org/podcast/pediatric-pain/)
New Emphasis on Nonpharmacologic Methods of Treating Pain in the ED
• Nonpharmacologic pain management techniques should be considered along with pharmacologic techniques and may:
  • decrease or avoid the use of opioids or anxiolytics
  • decrease time and recovery for procedures
  • decrease adverse events

Laceration example- distraction, wound glue, fan +/- nasal midazolam

• Pediatric versus adult
  • Although mainly used in children, many nonpharmacologic techniques and tools are helpful in adult patients especially those with autism or developmental delay

Nonpharmacologic Management in Pediatric ED and EMS Patients
• 80% of US children are seen in general EDs that will not have child life and other pediatric specific resources
• Emergency care providers are more likely to be motivated to use and learn nonpharmacologic methods for children
• Pediatric Education for Prehospital Professionals (PEPP) recommends a Distraction Toolbox

Step 7: Monitoring And Transfer of Care Checkpoint
• Document reassessments and pain scores after intervention(s)
• Make necessary adjustments
• Communicate, communicate……
• Run sheets, handoffs, transfers- last dose of analgesic
• Hospital Joint Commission standards and EMRs
• Falls prevention

Pharmacologic Treatment of Pain

Mild to Moderate Pain:
• NSAIDS

Moderate to Severe Pain:
• Consider an opioid analgesic or ketamine +/− NSAIDs or nitrous oxide

*if no contraindications exist and if supported by your local protocols

Treatment of Pain by Pre-hospital Providers

A strong recommendation has been made to consider all patients with acute traumatic pain as candidates for analgesia, regardless of transport time
**Moderate to Severe Pain - Opioids**

<table>
<thead>
<tr>
<th>OPIOIDS</th>
<th>INDICATION</th>
<th>DOSE/ROUTE</th>
<th>ONSET</th>
<th>DURATION</th>
<th>MAX DOSE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Moderate to severe pain</td>
<td>IV, SC, IM*</td>
<td>5-15 min</td>
<td>3-4 hr</td>
<td>10-15 mg or local protocol</td>
<td>Advantages Moderately rapid and predictable onset. Consider for patients who need prolonged pain control (e.g., fracture reduction, multiple trauma, sickle cell disease)</td>
</tr>
</tbody>
</table>

**Roxanol®**

- Morphine

**DOSE COMMENTS**

- *Always use the MOST concentrated form available and an atomizer.*
- Use concentrated solution
- Ketamine 50 mcg/ml
- Fentanyl 50 mcg/ml
- Midazolam 5mg/ml

**Ketamine (Ketalar®)**

- Provides analgesia while preserving airway patency, ventilation, and cardiovascular stability.
- Small doses may increase the analgesic potency of opioids. These features have increased the popularity of ketamine in patients with opioid-resistant pain (sickle cell vaso-occlusive pain crisis and other chronic pain disorders) or hemodynamically unstable trauma patients.

**Intranasal Medications**

- Use concentrated solution
  - Ketamine 50 mcg/ml
  - Fentanyl 50 mcg/ml
  - Midazolam 5mg/ml
- Use an atomizer
  - If > 1ml divide between nares
  - Aim spray toward turbinate/pinna
- Consider intranasal pain medications when IV access is not available or will delay care. Use an atomizer!

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Max Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ketamine*</td>
<td>0.5-1.0 mg/kg large range</td>
<td>Use caution until further studied</td>
<td></td>
</tr>
<tr>
<td>Fentanyl</td>
<td>1.5-2 mcg/kg</td>
<td>8 mcg/kg or 100 mcg</td>
<td>Divide dose equally between each nostril</td>
</tr>
<tr>
<td>Midazolam</td>
<td>0.3 mg/kg</td>
<td>10 mg or 1 ml per nostril (total 2 ml)</td>
<td>Divide dose equally between each nostril</td>
</tr>
</tbody>
</table>

*Always use the MOST concentrated form available and an atomizer.
* Dosing range not well established. Studies have used 0.5-9 mg/kg.

**Ketamine (Ketalar®) Indications**

<table>
<thead>
<tr>
<th>Indications</th>
<th>Starting Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedural Sedation</td>
<td>IV: Adult 0.5-1.0 mg/kg, Ped 1-2mg/kg; IM: 4-5 mg/kg</td>
</tr>
<tr>
<td>Sub-dissociative Analgesia</td>
<td>IV: 0.1 to 0.3 mcg/kg, max initial dose ≤ 10 mg IM: 0.5-1.0 mg/kg; IN*: 0.5-1.0 mg/kg</td>
</tr>
<tr>
<td>Excited Delirium Syndrome</td>
<td>IV: 1 mg/kg; IM: 4-5 mg/kg</td>
</tr>
</tbody>
</table>

*Dosing not well established. Studies have used 0.5-9 mg/kg.
So What is This Thing Called “Child Life”?

Certified Child Life Specialist (CCLS)

Certified Child Life Specialists (CCLS) are professionals who provide developmental, educational and therapeutic interventions for children and their families.

- Employed by hospitals/clinics with significant pediatric focus.
- Psychosocial preparation for diagnosis, tests, surgeries and procedures.

With appropriate preparation, distraction, +/- topical or local analgesia, a child may be capable of remaining still for ED procedures with minimal medications or restraint.

The Need for Child Life Specialists

- 2014 American Academy of Pediatrics policy statement: Child life Services (CLS) should be delivered as part of integrated patient- and family-centered model of care and included as a quality indicator in delivery of services for children and families in health care settings.
- Most EDs cannot provide CLS and certainly not 24/7.
- Solution: "Child Life 101 for Emergency Care Providers Course and a Distraction Toolbox!"

WARNING!

- Completion of this course does not make you a child life specialist
- Taking Stop the Bleed course ≠ trauma surgeon
- Taking first aid course ≠ nurse or paramedic

- Contact your local Children’s Hospital, Florida Association of Child Life Professionals (FACLP), or Association of Child Life Professionals

Questions? Ready for a Break?
Nonpharmacologic Pain Management

- Conversation and Therapeutic Language
- Coaching and Preparation
- Psychological and Cognitive Behavioral Interventions
- Physical/Sensory Interventions
- Distraction Toolbox Development

Nonpharmacologic therapy refers to interventions that do not use medications but can be used alone or to augment pharmacologic pain management. Most of these can be utilized for children and adults. Some options are not appropriate for ED/EMS: aromatherapy, hypnosis, TENS but that is changing.

- acupuncture example
- Empathy
- Cold or Hot packs
- Music
- Splinting or traction
- Caregiver assistance
- Guided imagery
- Non-pharmacologic options

Therapeutic Language-12 Tips

- Ask about and acknowledge the pain
- Recognize the value of listening
- Hard to do in a noisy ED or ambulance
- Pace the process respectfully
- May be difficult in emergency situation
- Define pain by framing it with hope not doom
- Avoid negative words and those that conjure fear
- Reframe the child’s distress

Adapted from: Lenora Kuttner, PhD.
A Child in Pain: What Health Professionals Can Do to Help. 2010
Suggested language for caregivers, parents and healthcare providers

<table>
<thead>
<tr>
<th>Language to Avoid</th>
<th>Language to Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will be fine, there is nothing to worry about (assurance)</td>
<td>What did you do in school today? (distraction)</td>
</tr>
<tr>
<td>This is going to hurt/this won’t hurt (vague, negative focus)</td>
<td>It might feel like a pinch (sensory information)</td>
</tr>
<tr>
<td>The nurse is going to take some blood (vague information)</td>
<td>First, the nurse will clean your arm, you will feel the cold alcohol pad, and next... (sensory and procedural information)</td>
</tr>
<tr>
<td>You are acting like a baby (criticism)</td>
<td>Let’s get your mind off it; tell me about that movie... (distraction)</td>
</tr>
<tr>
<td>It will feel like a bee sting (negative focus)</td>
<td>Tell me how it feels (information)</td>
</tr>
<tr>
<td>The procedure will last as long as... (negative focus)</td>
<td>The procedure will be shorter than... (procedural information)</td>
</tr>
<tr>
<td>The medicine will burn (negative focus)</td>
<td>Some children say they feel a warm feeling (sensory information)</td>
</tr>
<tr>
<td>Tell me when you are ready (too much control)</td>
<td>When I count to three, blow the feeling away from your body (coaching to cope; distraction, limited control)</td>
</tr>
<tr>
<td>Don’t cry (negative focus)</td>
<td>Your body is like a movie... (distraction)</td>
</tr>
<tr>
<td>It is over (negative focus)</td>
<td>You did a great job doing the deep breathing, holding still... (praised)</td>
</tr>
</tbody>
</table>

Training and Coaching

- Healthcare providers should:
  - Coach and prepare parents & caregivers for procedure, exam, transport, etc.
  - Provide “orienting” information
  - Discuss how to assist in their loved one’s coping ability
  - Initially discuss procedure away from child, if possible

ONE VOICE Philosophy

**ONE VOICE**

One voice should be heard during the procedure.
Need for parental involvement
Educate the patient before the procedure about what is going to happen.
Validate a child with your words.
Offer the patient the most comfortable, non-threatening position.
Individualize your game plan.
Choose appropriate distraction/coping techniques to be used.
Eliminate unnecessary staff who are not actively involved with the procedure.

Categorization of Nonpharmacologic Interventions

<table>
<thead>
<tr>
<th>Cognitive-Behavioral Interventions</th>
<th>Physical (Sensory) Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologic preparation, education, information</td>
<td>Positioning</td>
</tr>
<tr>
<td>Distraction (passive or active): Video games, TV, movies, phone</td>
<td>Cutaneous stimulation</td>
</tr>
<tr>
<td>Relaxation techniques (breathing, meditation, etc.)</td>
<td>Nonnutritive sucking</td>
</tr>
<tr>
<td>Music</td>
<td>Pressure</td>
</tr>
<tr>
<td>Guided imagery</td>
<td>Hot and cold treatments</td>
</tr>
<tr>
<td>Training and coaching</td>
<td>Others</td>
</tr>
<tr>
<td>Coping statements: “I can do this!”</td>
<td></td>
</tr>
</tbody>
</table>

ONE VOICE Summary

- Purpose of ONE VOICE philosophy is to remind health care professionals to be cognizant of environment we expose children to during medical procedures. Each letter of ONE VOICE stands for a different component of the environment.

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Phone: (402) 250-4824
Debbie@onevoice4kids.com
http://www.onevoice4kids.com

Adapted from Murray KK, Hollman EJ, Anesthesiology in the emergency department. The Lancet. 2015;1-10. nurses going to kids sprague circle Omaha, NE 68134 Phone: (402) 250-4824 Debbie@onevoice4kids.com 3/14/2018
Cognitive Development

• Because young children are cognitively immature, physical comfort measures and distraction activities are more effective than verbal reasoning.

• Children do not have sufficient cognitive development to understand strangers trying to reassure them until age 5-7 years.

Physical (Sensory) Interventions:
usually inhibit nociceptive input and pain perception

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<tbody>
<tr>
<td>Positioning</td>
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<tr>
<td>Cutaneous stimulation</td>
</tr>
<tr>
<td>Nonnutritive sucking +/- sucrose solution</td>
</tr>
<tr>
<td>Pressure</td>
</tr>
<tr>
<td>Hot and cold treatments</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Comfort Positioning

• Why use positioning for comfort?
  • Sitting position promotes sense of control and reduces anxiety
  • Puts child in a secure, comforting hold
  • Promotes close contact with caregiver
  • Provides caregiver with an active role

May be prohibited in trauma patients requiring immobilization and transport.

Nonnutritive Sucking

• Pacifier in conjunction with sucrose has analgesic effect in neonates undergoing venipuncture and reduces crying in infants < 6 months of age.
• Easy to use in ED and EMS settings
• Conflicting studies

Cutaneous Stimulation

• Vibrating palm-sized devices with removable ice wings available commercially. Studied for injections and IVs with relief similar to topical analgesic cream or spray.
  • Dentist jiggling the jaw before a block
Gate Control Theory of Pain

- In order to help control the "gate" of pain, other tools can be utilized to distract/"trick" the skin or body to focus on additional sensations, such as alternative focus, cold or vibration, to minimize the sensation of the pain.
- The proposed mechanism of action involves the gate control theory of pain whereby the sensation of touch competes with the sensation of pain for transmission to the brain, resulting in less pain.
- This technique is often referred to as providing "white noise."

Cold Therapy for Musculoskeletal Injuries

- Rest
- Ice
- Compression
- Elevate
- Splinting
- Dressing
- Positioning

Ice or cold packs reduce swelling and pain in strains, sprains and fractures. Do not put directly on bare skin.

Heat Therapy

Active warming may reduce pain, anxiety, nausea, and heart rate in patients with pain related to mild trauma, cystitis, urethritis, cholecystitis, appendicitis, and colitis.

- Applied in 20 minute time periods to affected areas
- Beware of extreme heat and burns
- Heat acts by: 1. increasing blood flow to skin; 2. dilating blood vessels, increasing oxygen and nutrient delivery to local tissues; and 3. decreasing joint stiffness by increasing muscle elasticity.

Benefits Of Keeping Patients Warm

- EDs and ambulances often are cold, drafty, and without blankets
- Cold exposure is especially detrimental in patients with Raynaud’s syndrome or disease, collagen vascular diseases like Lupus and Scleroderma, and those on cardiovascular and blood thinning medications.
- 5-10% of the general population has primary or secondary Raynaud’s Disease or symptoms.
- Consider warm blankets or warmed fluids.

Cognitive-Behavioral Techniques

<table>
<thead>
<tr>
<th>Types of Cognitive-Behavioral Interventions</th>
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<tbody>
<tr>
<td>Psychologic preparation, education, information</td>
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<td>Distraction (passive or active): Video games, TV, movies, phone</td>
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<td>Coping statements: “I can do this” or “this will be over soon”</td>
</tr>
</tbody>
</table>

Distraction

Distraction is the most common type of cognitive-behavioral method.

Used to guide attention away from painful stimuli. It is most effective when adapted to the patient’s developmental and cognitive level.

Research indicates that distraction can lead to reduction in procedure times and number of staff required, especially in children. Researchers hypothesize that children “cannot attend to more than one significant stimulus at a time.”

Why use distraction?

- Does not require advanced training for providers.
- Works with all developmental levels.
- Involves parents and caregivers during stressful times.

Tips:

- Distraction is most effective when pain is mild to moderate.
- It is difficult to concentrate when pain is severe.
Two Types of Distraction

1. Passive Distraction - attention redirected to a pleasurable stimulus or object
   • Storytelling
   • Showing a toy

2. Active Distraction - encourage participation in activities during procedure
   • Blowing bubbles
   • Playing a game
   • Interacting with electronic device

Can be used together or alone

Distraction versus Planned Alternative Focus

• Distraction: Diverting or redirecting attention to reduce anxiety due to medical environment.

• Planned alternative focus: Concept of using patient’s volition to successfully complete procedures for sense of mastery and ownership.


Distraction or Alternative Focus

• Should not be seen as “tricking” the child as this can result in a loss of trust
• Gives the patient a “job” and promotes sense of control over an appropriate aspect of the procedure
• Best if child is involved in choosing the form of distraction to be used during the procedure

Conversation and Distraction

Conversation is a proven method of patient management and helps reduce anxiety and pain through distraction. Pain can be reduced by up to 25% by distraction alone.

Conversational distraction is better for managing pain and anxiety than passive distraction.

Conversation topic ideas: family, hobbies, vacation, sports


The ABC’s of Distraction

A – Assorted visuals
B – Breathing techniques
C – Comfort Positions
D – Diversional Talk
   • Give a choice only when choice exists
   • Limit number of voices
E – Encouragement and praise
   • Specific - “You’re doing a good job taking deep breaths” instead of “Good boy”
Guided Imagery

- Helps patients use imagination to divert thoughts from the pain or procedure to a more pleasant experience.
- Helps patients use their imagination to create a descriptive story.
- Guided Imagery Options

<table>
<thead>
<tr>
<th>Option 1</th>
<th>Visit a “relaxing” place and change image of pain or turn off pain with a “pain switch” in the brain. Ask patient to locate the pain switch and turn down level of pain to a more comfortable level.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 2</td>
<td>Identify a “pain” color and a “comfort” color. Ask patient to breathe in the “comfort” color and breathe out “pain” color OR ask patient to associate their pain with a color then view the painful part of their body in that color. Imagine shrinking, fading, or dispersing the painful color, or even sending it away in a balloon.</td>
</tr>
<tr>
<td>Option 3</td>
<td>Symbolic imagery can be used in adults and adolescents. If a patient with severe arthritis pain complains of pain in one joint, ask them to think about how the pain feels. Does it feel like a knife? Imagine pulling the knife out and throwing it away. Focusing on an affirmation can also help. “I am removing the knife and throwing it away”.</td>
</tr>
</tbody>
</table>

Relaxation Techniques

Goal is to produce the relaxation response, “a physical state of deep rest that changes physical and emotional responses to stress (e.g. decreased HR, BP, RR, and muscle tension).”

- Progressive muscle relaxation
- Diaphragmatic breathing

Progressive Muscle Relaxation (PMR)

- Helps patients recognize difference between tensed and relaxed muscle groups

How to use

- In a calm voice, instruct patient to tighten and relax muscles. Start with the forehead and gradually move down the muscle groups in the body. Example: Forehead, jaw, back, etc.

Diaphragmatic Breathing (Belly Breathing)

- Patient breathes through abdomen (belly) instead of chest and counts slowly with each breath in and out to a predetermined number. This works best with at least 8 breaths per minute.
- Instruct patient to place hands on abdomen and watch their hands rise and fall with each breath. Seeing hands move up and down provides instant feedback. Best to implement during an IV attempt or with an anxious child (or parent)! Young children can be taught “belly breathing” while blowing bubbles, pinwheels, or party blowers.
- For deep breathing, have child pretend to blow out birthday candles on a cake or blow up a balloon. Talk about balloon color of how cake is decorated.

Music Therapy

- Additionally benefits parents and health care providers caring for the anxious patient
- Many larger hospitals have music therapists or volunteers
- Request ED time

Ways to implement:

- Play in waiting areas
- Have patient select music from available electronic devices or their own- keep supply of disposable headphones or earbuds

Beneficial in reducing pain, anxiety and stress in EDs, waiting rooms, procedure rooms, and during transport.
NPR: “Reach for Playlist Instead of Popping a Pill”

- Children who choose their own music or audiobook to listen to after major surgery experience less pain.

Parents/kids will remember the Wikki Stix or your calm voice before they will remember your new monitor, truck, uniform, etc.

PAMI Distraction Toolbox Project: *Box, bag, backpack, room, or cart*

Designing Your Distraction Toolkit

- Components
- Safety
- Setting

Distraction Toolbox Components

- LED keychains
- Rubik’s cube
- Mad Libs
- Stress Balls
- Stickers
- Buzzy – cold, numbing, vibrating
- Liquid-in-motion
- Lighted & motion toy
- Wicki Stix
- Pacifier & Sucrose Water
- Heat/cold packs
- DistACTION Cards
- Glitter Spy wand

Distraction Toolbox Components

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ED versus EMS Toolbox

- EMS:
  - Limited space for storage, regulations
  - Toolbox - small and heavy duty
  - Bag or backpack in a designated area
  - Short ambulance rides vs. longer interfacility transports

- ED’s
  - Have more space: a designated room, closet, cart, or toolbox
  - Volunteers, patient care advocates, or other appropriate staff
  - Can incorporate many different options
  - Beware of siblings or other children in the room

Patient Safety Considerations

- Infection Control
  - Individual use - child keeps or disposes of the item (teddy bear, pacifiers, teethers, Wikki Stix, ice packs)
  - Multiple use items: ensure item can be sanitized (local policies)

- Choking Hazards
  - Make sure item is age appropriate
  - No small pieces or easily breakable toys (<3 years or older if developmentally delayed)
  - Ensure items with gel or liquid ingredients are nontoxic

Special Safety Situations

- Extremely anxious parents
- Abusive behavior
- Patient with suicidal tendencies or mental illness
- Children with no caregiver present

Nonpharmacologic Therapies: Infants

- Swaddling
- Holding
- Rocking
- Sucking
  - Sucrose pacifier (Sweet-Ease 24% sucrose solution)
  - Non-nutritive sucking
- Dim lighting
- Music
- Toys
- Key chains
- Rattles
- Blocks

Nonpharmacologic Measures: Toddlers

- Distraction with music
- Light touch or massage
- Repositioning, splinting
- Cold or hot pack
- Cause and effect toys
- Toys with lights and noise
- Drawing with crayons and paper
- Picture reading
- Encourage singing
- Blowing bubbles

Nonpharmacologic Measures: Preschoolers

- Provide calmest environment possible
- Cold or hot packs
- Allow position of comfort if safe
- Light touch or massage
- Music or video on phone or iPad
- Stress ball, pinwheels, bubbles
- Toys with lights and sounds
- Distraction cards, find objects
- Look at or read storybooks
- Singing or storytelling
- Distracting conversation
- Coach child through the process
Nonpharmacologic Measures: School Age

- Provide calmest environment possible
- Music, phone videos or apps, books
- Coach child through the process and/or procedures
- Provide light touch or massage
- I-spy books
- Stress balls
- Cold or hot packs
- Relaxation techniques such as breathing exercises
- Encourage conversation about favorite things
- Electronic games

Nonpharmacologic Measures: Adolescent

- Cold or hot packs
- Suggest repositioning or positions of comfort
- Encourage talking about favorite places or activities
- Light touch or massage
- Music or videos
- MadLibs
- Coach about EMS/ED process and procedures
- Discuss preferred relaxation techniques
- Demonstrate relaxation techniques, if unfamiliar
- Stress squeeze balls
- Encourage making choices
- Electronic games or tablets

Summary

- Pair nonpharmacologic techniques with pharmacologic management especially topical anesthetics or blocks
  
  Example: wound glue and fan or distraction for laceration repair

- Adapt choice and pacing of the distraction activity or technique to individual child’s interests and personality
- Pair two senses for improved distraction
  - (lights and sounds, touch and sound)
  - Distraction activities can also be used after a procedure or painful event to assist in emotional recovery
- Partner with a Child Life Specialist for training or new ideas

Questions?

- Other ideas
- Input
  - Tools for EMS vs ED vs Hospital vs Clinic
  - Go get your toolbox!

Agenda-Part 3

11:15-12:15: Putting It All Together-Program Implementation, Resources and Evaluation

- Case Scenario Discussion
- Educational Resources, Supplies and Videos
- Implementation in your Agency, Hospital, Community
- Community Resources and Networking Opportunities
- Feedback and Questions
- Name This Course

Poll Everywhere: Help us name this course!

In order to participate in our poll to name this course:

- Text: PAMIED777 to 22333 from your cell phone
- You should receive a confirmation text

You are now ready to vote at the end of this course!
Case Scenario: Head Trauma & Laceration

Rescue is called to the house of a 4 year old boy who cut his forehead after a fall while running. He had a brief LOC. Initially the boy was calmly sitting in his mother’s lap but now begins to cry, throws his toy truck at the paramedic’s face. Blood is dripping down his face. His mother is crying and asks if you will “report her”.

*What can be done to help calm the child and mother in order to perform further evaluation of the injury?*

Case Scenario: Laceration continued

Upon arrival to the ED they are greeted by the treatment “team”. The ED physician comments, “That cut is pretty deep. It’s going to need stitches. Don’t worry, it will only hurt a little. You won’t remember any of it after we put you to sleep”. He tells the nurse to start an IV and leaves the area.

*Is the physician’s language developmentally-sensitive?*
*What unintended consequences may occur?*

Case Scenario: Burn

• A 6 foot, 200 pound 18 year old with cerebral palsy and development delay was burned by boiling water. He is now crying and thrashing with obvious full-thickness burns to chest, arms, and hands.

• A 2 year old pulled a pot of boiling water and pasta off the stove. She has burns on her arms, chest and face. She is screaming and running away from you- at the scene, in the ED.

*Would you handle these two cases the same?*

Case Scenario: Burn

You decide to use the FLACC pain scale and determine she has a pain rating of 8. Patient likely would benefit from pharmacologic and nonpharmacologic management.

Pediatric Case Scenario- Management Determined Using Stepwise Approach

1. Situation Checkpoint
2. Developmental or Cognitive Checkpoint
3. Family Dynamic Checkpoint
4. Facility Checkpoint
5. Patient Assessment Checkpoint
6. Management Checkpoint
7. Monitoring & Discharge
Pediatric Case Scenario
Management and Conclusion
1. Interactive distraction- show a lighted toy
2. Comfort positioning- caregiver presence
3. Using developmentally-sensitive language- “You are brave” instead of “I am sorry”
4. Attempt IV x 2 without success
5. Give IN fentanyl and cover burn
6. Pain level decreases to a 6 which makes it easier for trauma center staff to attempt IV access upon arrival and keep family calm. Morphine given in ED/Trauma center.

Case Scenario: Car Crash
On a rainy Saturday night, a father of 3 loses control of his car at 50 mph. Roll over with mother, father and 3 children in the car. Family is driving home after a trip to Disney. Everyone is awake and screaming when you arrive. Primary survey good but….blood, glass, deformed extremities, tachycardia, pain and anxiety!

How can you differentiate tachycardia from pain and anxiety versus shock or cardiorespiratory compromise?

Case Scenario: Car Crash, 8 YO Transport
Patient has an obvious fracture and tells you he caused the accident by begging his Dad to give him the phone because he was bored during the drive…. “Is his Dad going to die?” Do you……
- Secure him to a hard plastic board
- Wrap collar around neck
- Place in back of ambulance without a family member and drive over bumpy roads to a strange unknown place
- Arrive at the hospital and leave child on a backboard until after triage and ED physician evaluation
- Avoid starting an IV due to short transport time or give only 1 mg of morphine?

Case Scenario: Past History
5 year old female with obviously deformed forearm S/P fall off playground equipment arrives via EMS from school. She is crying hysterically and saying “Please don’t tell my momma I was a bad girl”. Father arrives ten minutes later and appears quiet and exhausted. ED/EMS staff is concerned that he doesn’t seem to be doing anything to comfort his daughter. You ask if he has notified the child’s mother of the accident. The child’s eyes light up but he shakes his head. Finally you ask why he has not called the girl’s mother; he responds “She died 3 months ago”…

How do past experiences influence responses to pain and traumatic events?

Adult Case Scenario
Rescue arrives at the home of an 85 yo female who fell down the stairs. EMS performs a quick assessment and determines that her left ankle is swollen and tender. She appears anxious and in pain, reported as a 9/10. They immobilize her ankle and establish an IV. During transport the patient begins to cry and states “now my children will make me sell my house and go into a nursing home”.

What other treatments and techniques can be used to address this patient’s anxiety and pain in addition to IV medications?

Adult Case Scenario Discussion
Nonpharmacologic options:
- distraction
- splinting
- elevation of affected extremity
- Interactive distraction
- Distraction through conversation while performing secondary assessment during transport to hospital
- Conversation starters include family, hobbies, etc.
- Orienting information: where you are taking patient, what to expect, offer to call family or friends
Adult Case Scenario

The patient is handed off to the ED team. Treatments and techniques started in the field are continued in the ED and the patient’s anxiety and pain improves to a 3/10. Daughter arrives at the ED and thanks EMS/ED for calling. Patient is admitted with ankle and hip fractures. One month later, patient writes a letter to her local newspaper praising the county EMS service.

Case Scenario- EMS triage sets the tone

- 18 yo BM transported for SS pain. Took one dose of “Norco” about 6 hours ago... just looking for dilaudid or something IV. Hasn’t called his regular doctor......
- Triage nurse to doctor- 18 yo SS patient in room 4 looking for drugs
- Resident to attending- SS drug seeker in room 4, doesn’t look like he’s in pain to me
- Attending physician: goes into room 4 with preconceived attitude
- The rest of the story........
- Always take your own history!

Nonpharmacologic Pain Management in Special Populations

- Nonpharmacologic measures are excellent adjuncts in other special populations including:
  - Patients with autism or developmental delay
  - Patients with anxiety or mental disorders
  - Chronic pain patients or patients already on high dosages of pain medications

Resources: Literature, Videos, Websites, Apps, Vendors and More!

- Many excellent resources available
- PAMI website will include a list of resources and references
- Let us know if you have suggestions or see something new

Distraction therapy: Hospital room designs help ease tension


Distraction Resources-See Handout

- Apps
- Music
- Games

The Power of Videos and Cute Kids!

- Managing Procedural Anxiety in Children
- It Doesn’t Have to Hurt: Distraction
  - https://www.youtube.com/watch?v=KgBwVSYqfps
- Baby Getting Shots
  - https://www.youtube.com/watch?v=MOOxpT9q2mo
- Coping with Healthcare Procedures
  - http://www.chop.edu/health-resources/coping-healthcare-procedures#.VeXEQn1v_eI

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### Need Ideas for Patients? Interactive Play-Kinesthetic Apps

<table>
<thead>
<tr>
<th>Name of App</th>
<th>Age/Development</th>
<th>Tips for Use</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toca Pet Doctor &amp; Toca Doctor</td>
<td>3-6 years</td>
<td>The pets need your help! Animal friends is perfect for your love, care, and help.</td>
<td>Free</td>
</tr>
<tr>
<td>Doodle Great</td>
<td>3-100 years</td>
<td>Try to lead a space or write with this interactive game. An excellent choice for single players or engaging siblings or family members as well.</td>
<td>Free</td>
</tr>
<tr>
<td>Fruit Ninja</td>
<td>0-18 years</td>
<td>A popular lawen favorite provides distraction while trying to slice fruits and avoid bombs.</td>
<td>Free</td>
</tr>
<tr>
<td>Candy Pizza Maker</td>
<td>6-12 years</td>
<td>Who doesn’t love pizzas and chocolates? Kids will love to create their own recipes. Request sprinkles while they make it to build rapport!</td>
<td>Free</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Music Programs</th>
<th>Age/Development</th>
<th>Tips for Use</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spotify</td>
<td>3-85 years</td>
<td>Kids Stations; Great for Adolescents - may already have a playlist, suggest they listen while in the ED, EMS so long does not interfere with care.</td>
<td>Free</td>
</tr>
<tr>
<td>Pandora</td>
<td>All ages</td>
<td>From infants to adults, customize stations to soothe and distract patients of all ages.</td>
<td>Free</td>
</tr>
<tr>
<td>Animal Planet</td>
<td>1-7 years</td>
<td>Excellent active participation for toddlers and elderly school age children who “play” the piano which has 3 different animal noises. Giggles are sure to occur!</td>
<td>Free</td>
</tr>
<tr>
<td>Talking Tom &amp; Ben News</td>
<td>3-12 years</td>
<td>Whimsical Voice Mutation with interactive cat and dog.</td>
<td>Free</td>
</tr>
</tbody>
</table>

### Games

<table>
<thead>
<tr>
<th>Name of Game</th>
<th>Age/Development</th>
<th>Tips for Use</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumino</td>
<td>&gt;7 years</td>
<td>Offer this classic game to patients of all ages. Excellent for sensory experiences and anxiety.</td>
<td>Free</td>
</tr>
<tr>
<td>Board Game Collection</td>
<td>&gt;7 years</td>
<td>A collection of classic board games from around the world including tic-tac-toe, checkers, and Connect-Four which will provide distraction for patients of all ages.</td>
<td>$2.99</td>
</tr>
<tr>
<td>Uno</td>
<td>&gt;5 years</td>
<td>This classic card game brings out the competitive streak in children and adults! Options for individual play or teams can even engage anxious family members.</td>
<td>Free</td>
</tr>
<tr>
<td>Toca Chalk</td>
<td>&gt;12 years</td>
<td>Patients can select categories and distract themselves from pain while testing random knowledge. Play along with them to build trust!</td>
<td>Free</td>
</tr>
</tbody>
</table>

### Additional Thoughts

- Ask family and friends of the age group you want to target what they use.
- Search the App Store. New apps and updates are released daily!
- Beware if you are “streaming” - download costs$5
- Most hospitals have free or guest Wi-Fi service
- Does your ED have free Wi-Fi for patients?
- What about EMS?
- Clean your device with -Sani-Cloth CHG 2% (chlorhexidine 2%/alcohol 70%)
Amazon Prime or Xfinity: download movies, cartoons, and TV shows to your phone, IPAD or device

- Great for any age, particularly children & adolescents
- If patient has their own phone/tablet, suggest they watch something if that is a possibility

Video Examples of Distraction

- 13 yo Piano App IV
  https://youtu.be/21MaSqf6SWQ
- 3 yo Pediatric I Spy Wand Distraction
  https://youtu.be/audRcLtevnM
- Ginger
  https://youtu.be/vZNdQMFEu1Q
- 6 yo Pediatric iPad Distraction Asthma
  https://youtu.be/loPdvS_apZc

How to Implement and Fund a Program

- Identify champions and stakeholders
- Host a training program or provide Child Life 101 and Distraction Toolbox training materials
- National EMS Week
- Emergency Nurses Week
- ED Techs or volunteers
- Identify community partners
- Almost everyone loves to help injured or ill children
- Determine grants and donor sources
- Manufacturers of distraction products
- Restaurants
- State and local grants
- Foundations

Distraction Supply Resources

- Amazon- create a wish list
- Specific manufacturers- often donate to nonprofit causes
  Wikki Stix- www.wikkistix.com
- Dollar stores
- Art supply stores
- Special thanks to Kessler Creative and Stack-On Products

Other Great Resources- Those Canadians and Aussies!

http://vkc.mc.vanderbilt.edu/audibloodwork/pdfs/ProviderGuide.pdf
"Take the work out of Bloodwork" - a guide from Autism Speaks for clinicians to help patients with ASD to cope with bloodwork draws
http://www.rch.org.au/comfortkids/
Program at The Royal Children's Hospital Melbourne (Australia) with practical handouts and activities for kids, parents and health professionals.
http://pediatric-pain.ca/it-doesnt-have-to-hurt
Resources, strategies, research and tips from the Centre for Pediatric Pain Research around supporting kids through painful procedures.
Tips and Tools to Create your Own Comfort Kit from the Child Life Specialists at Hospital for Sick Children.
http://fsen.capfr.org/exwiki/bin/view/Pediatric+Pain/Distraction+Toolkit

We Need Your Vote!!
Name This Course

https://PollEv.com/multiple_choice_polls/IIVFgZC2n1MXVv3/web

A. New Approaches to Pain - Turn Down the Drugs and Increase the Fun: Exploring Nonpharmacologic, Child Life & Distraction Techniques for Pain Management in Emergency and Acute Care Settings
B. Change Your Approach to Pain - Turn Down the Drugs and Turn up the Fun: Exploring Nonpharmacologic, Child Life & Distraction Techniques for Pain Management in Emergency and Acute Care Settings
C. New Approaches to Pain - Less Pharm, More Fun! Exploring Nonpharmacologic, Child Life & Distraction Techniques for Pain Management in Emergency and Acute Care Settings
D. Nonpharmacologic Pain Management for Emergency Care Providers: What's the Secret Recipe?
E. Nonpharmacologic Pediatric Pain Management Interventions: Child Life 101 and Distraction Toolbox for Emergency Care Providers
F. Other
### Group Feedback

- Length of course
- Materials
  - ED vs EMS
- What needs to be added or deleted
- Other suggestions
- Look for us at SAEM May 2017 and ClinCon July 2017
  - Orlando

### Questions and Comments

References and resources can be found on the main PAMI website: [http://pami.emergency.med.jax.ufl.edu/](http://pami.emergency.med.jax.ufl.edu/)

Email your comments, ideas, change of practice, recommendations, challenging cases, and questions.
(904) 244-4072 or 244-8617
emresearch@jax.ufl.edu
phyllis.hendry@jax.ufl.edu
## Responses to Pain by Age or Development

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Understanding of Pain</th>
<th>Behavioral Response</th>
<th>Verbal Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>No understanding of pain; is responsive to parental anxiety</td>
<td>Generalized body movements, chin quivering, facial grimacing, poor feeding</td>
<td>Cries</td>
</tr>
<tr>
<td>6–12 months</td>
<td>Has a pain memory; is <strong>responsive to parental anxiety</strong></td>
<td>Reflex withdrawal to stimulus, facial grimacing, disturbed sleep, irritability, restlessness</td>
<td>Cries</td>
</tr>
<tr>
<td>Toddlers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1–3 years</td>
<td>Does not understand what causes pain and why they might be experiencing it</td>
<td>Localized withdrawal, resistance of entire body, aggressive behavior, disturbed sleep</td>
<td>Cries and screams, can’t describe intensity /type of pain; <strong>Use words for pain such as owie and boo-boo</strong></td>
</tr>
<tr>
<td>Preschoolers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3–6 years (preoperational)</td>
<td>Pain is a hurt; Does not relate pain to illness; Often believes pain is punishment; Unable to understand why a painful procedure will help them feel better or why an injection takes the pain away</td>
<td>Active physical resistance, directed aggressive behavior, strikes out physically and verbally when hurt, low frustration level</td>
<td>Has language skills to express pain on a sensory level; Can identify location and intensity of pain, denies pain, may believe his or her pain is obvious to others</td>
</tr>
<tr>
<td>School-Age Children</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7–9 years (concrete operations)</td>
<td>Doesn’t understand cause of pain; Understands simple relationships between pain and disease and need for painful procedures to treat disease; May associate pain with feeling bad or angry; recognize psychologic pain related to grief and hurt feelings</td>
<td>Passive resistance, clenches fists, holds body rigidly still, suffers emotional withdrawal, engages in <strong>plea bargaining</strong></td>
<td>Can specify location and intensity of pain and describes pain physical characteristics in relation to body parts</td>
</tr>
<tr>
<td>10–12 years (transitional)</td>
<td>Better understanding of relationship between an event and pain; More complex awareness of physical and psychologic pain, (moral dilemmas, mental pain)</td>
<td>May pretend comfort to project bravery, <strong>may regress with stress and anxiety</strong></td>
<td>Able to describe intensity and location with more characteristics, able to describe psychologic pain</td>
</tr>
<tr>
<td>Adolescents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13–18 years (formal operations)</td>
<td>Has a capacity for sophisticated and complex understanding of causes of physical and mental pain; Recognizes pain has qualitative and quantitative characteristics; <strong>Can relate to pain experienced by others</strong></td>
<td>Want to behave in socially acceptable manner -like adults; controlled response; May not complain if given cues from other healthcare providers</td>
<td>More sophisticated descriptions with experience; may think nurses are in tune with their thoughts, so don’t need to tell nurse about their pain</td>
</tr>
<tr>
<td>Language to Avoid</td>
<td>Language to Use</td>
<td></td>
<td></td>
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<tr>
<td>--------------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You will be fine; there is nothing to worry about</td>
<td>What did you do in school today? (distraction)</td>
<td></td>
<td></td>
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<tr>
<td>(reassurance)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>This is going to hurt/this won’t hurt (vague; negative</td>
<td>It might feel like a pinch (sensory information)</td>
<td></td>
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<tr>
<td>focus)</td>
<td></td>
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<tr>
<td>The nurse is going to take some blood (vague information)</td>
<td>First, the nurse will clean your arm, you will feel</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>the cold alcohol pad, and next... (sensory and</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>procedural information)</td>
<td></td>
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<tr>
<td>You are acting like a baby (criticism)</td>
<td>Let’s get your mind off of it; tell me about that</td>
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<tr>
<td></td>
<td>movie... (distraction)</td>
<td></td>
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</tr>
<tr>
<td>It will feel like a bee sting (negative focus)</td>
<td>Tell me how it feels (information)</td>
<td></td>
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</tr>
<tr>
<td>The procedure will last as long as... (negative focus)</td>
<td>The procedure will be shorter than... (television</td>
<td></td>
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<tr>
<td></td>
<td>program or other familiar time for child);</td>
<td></td>
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<tr>
<td></td>
<td>(procedural information; positive focus)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The medicine will burn (negative focus)</td>
<td>Some children say they feel a warm feeling (sensory</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>information; positive focus)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tell me when you are ready (too much control)</td>
<td>When I count to three, blow the feeling away from</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>your body (coaching to cope; distraction limited</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>control)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am sorry (apologizing)</td>
<td>You are being very brave (praise; encouragement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don’t cry (negative focus)</td>
<td>That was hard; I am proud of you (praise)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is over (negative focus)</td>
<td>You did a great job doing the deep breathing,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>holding still... (labelled praise)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tips for Working with Children with Autism Spectrum Disorders

Parents/Caregivers

- Ask the family how we can best help them - they are your greatest resource for information!
- Ask the family, what types of things are calming for their child, and if their child has any sensory sensitivities. This can help you avoid issues before they happen.
  - (i.e. hypersensitive to sound, light, sensitivity to particular textures, smells, etc.) - and try to minimize those stimuli
  - Identify possible triggers for that child
  - Identify if the child has any activities they find soothing (i.e.: rocking, chewing, massage, etc.) - and help facilitate them
- Ask them if their child has a specific like – electronics, trains, dinosaurs etc. that may help you connect with or distract the child during their time with you.
- Be creative when possible. These children don’t always fit into the mold of what a typical patient will be. Think about what you need from them that is truly a necessity in order for you to treat them.

Waiting Room and Rooming the Patient

- Accommodate for Waiting
  - Consider alternate areas the child can wait that are not as over stimulating as the waiting room
    - Is there a room with a door available in another area that can be used while the patient is waiting?
  - When Rooming a Patient - If possible, use a private room with a door, not close to an Exit
  - Avoid curtained rooms if possible

Sound/hearing

- Keep external noises limited
  - use a white noise machine in their room if available
  - have soft music playing in the background (online streaming)
  - speak in a calm voice at all times
  - many of these children have sensitivities to noise

Light/Vision

- Keep overhead lights to a minimum when they are not necessary
- Prepare the child when you are going to turn on a bright light so they can cover their eyes if they wish
- If appropriate, provide sensory toys

Interaction/Social/Communication

- Try to limit the number of people coming into and out of the room (Share this information with entire team.)
  - Consider creative ways to identify a room with a patient who requires special considerations.
- Use a calm voice and simple language (“less is more”) when asking the child questions and give them time to respond to you.
- Stay away from sarcasm, euphemisms, and words with double meaning as they are difficult to understand
- Many children do better if they are given information about the sequence of events. Tell the child what will happen before it happens, in simple language. This can begin as early as meeting the patient and family in the treatment area or the waiting room.
- Just because the child is non-verbal does not mean they do not understand you or cannot communicate-check with the family for more information about the child best communication methods.
• Sometimes children are very overwhelmed and will scream or shout. They may be telling you they need a break (when possible) and a chance to regroup.

Touch
• Ask family about their child’s specific sensory needs so you can be aware and incorporate them into your care whenever possible.
• Soothing touch may be over stimulating and anxiety producing for some children. Instead, speak with caregivers about the best way to provide tactile support during the visit or procedure.
• Heads can be extremely sensitive; ask the child or caregiver if the touch would be calming.
• These children sometimes operate in a state of “Fight or Flight” and what seems to be the littlest thing (like applying a bandage) can be difficult for them. Allow them additional time to accommodate to what is going on around them and to them.

During Procedures
  • Prepare the child before procedure
  • Use simple and concrete language
  • Explain the series of events
  • Utilize parents to find out what will work best for their child for the procedure
  • Limit the number of staff speaking- the child will likely become overwhelmed by the number of voices
  • Keep voices low and calm
  • Limit the number of staff touching the child as much as possible- some children may have sensitivity to touch and become overwhelmed. A papoose, even for older children, may be calming. An x-ray lead gown can be used as a weighted blanket.
  • Engage and encourage caregiver participation whenever possible. Even is parents appear overwhelmed and are unsure of how to help, they can still offer guidance about techniques which would be most upsetting for their child.

Suggested Script:  I would like to talk about when we are going to give your child the sedation medicine. This can be a surprising experience for some families and things can happen at a rapid pace so we would like you to be aware of what we are doing in advance, answering any questions you may have.

For this study, it is necessary for your child to be motionless for an extended period of time. The medication the doctor has chosen, allows us to keep your child in this state for the duration of the test safely. The doctor will give your child medication through the IV to get them into a sleep state and then continuously through the IV to keep them asleep during the study.

There are several pieces of equipment you will see in the room. For example, an oxygen mask, monitoring equipment to watch their heart rate and breathing, and the IV pump to deliver the medications. There will be a nurse, the doctor and the MRI tech here during the sedation time. You may be right here with your child until they fall asleep if you choose to do so.

We encourage you to gather your valuables to take to the waiting area before we start giving sedation medicine. We can store your child’s clothing while they are having their test. You will be allowed to give your child a kiss if you would like, then be escorted by a staff member to the waiting room so your child may complete the testing.

Sometimes the medicine can be irritating to the skin when giving the first dose, however, the sensation does not last long. Numbing medicine has been added to help decrease the irritation. The nurse or doctor may rub the site just above the IV to help decrease this sensation.

Your child may try to turn or roll over into a position they feel comfortable. This is normal. The nurse, doctor and MRI tech will make sure they are safe on the stretcher and do not harm themselves. At this point, the doctor may need to give more medication to get them into a deeper sleep state.

Once your child is resting quietly, we will place monitoring equipment on their chest to watch heart rate and breathing. We will also place a finger monitor to watch oxygen level. The doctor may place a towel roll under your child’s shoulders or reposition their head. This allows air to move easily in and out of the lungs as they sleep.

What questions or concerns do you have about sedation? Did you understand everything I have discussed with you?
You can help your child build courage and confidence!

Help your child talk about their feelings.

Help your child find ways that they can help themselves feel better.

Help your child keep busy so their wait and their worry are not annoying to them.

Help your child learn the names of the people taking care of them.

Help your child know that they are safe.

Help your child by setting a calm example.

Children cope best when they have information about what is happening.

Children like coping strategies that they can do themselves.

Children build understanding through play and exploration.

Children gain a sense of control when they feel like they are heard.

Children develop trust when they can count on being treated with honesty and fairness.

Alexandra Rivera 2014
Ed. Kathleen Plymel, CCLS 2017
BRAVERY BOOST

PLAY THE WORRIES AWAY!

EXPLORE

5, 4, 3, 2, 1
Name 5 things you can see right now,
Name 4 things you can feel right now,
Name 3 things you can hear right now,
Name 2 things you can smell right now,
Name 1 good thing about yourself.

BE BUBBLY

Blow bubbles. Ask for some.

Cuddle & Soothe

Comforting touch.

TECH-IT

Smart phones and tablets...

PRETEND

Think of a place that you would rather be. Tell a story...

READ

Grab a book off the shelf or ask for one.

How would a character in the book feel if they were in the hospital?

TRY CANDY CRUSH, SIMPLY SAYIN', OR FIREWORKS.

RAP, HUM, OR SING A LULLABYE OR A HAPPY SONG.

COMFORTING TOUCH.

5, 4, 3, 2, 1
Name 5 things you can see right now,
Name 4 things you can feel right now,
Name 3 things you can hear right now,
Name 2 things you can smell right now,
Name 1 good thing about yourself.

TECH-IT

Smart phones and tablets...

PRETEND

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READ

Grab a book off the shelf or ask for one.

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RAP, HUM, OR SING A LULLABYE OR A HAPPY SONG.

COMFORTING TOUCH.

5, 4, 3, 2, 1
Name 5 things you can see right now,
Name 4 things you can feel right now,
Name 3 things you can hear right now,
Name 2 things you can smell right now,
Name 1 good thing about yourself.
## Apps & Resources for Distraction

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Price</th>
<th>Logo</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interactive Play-Kinesthetic (Apps)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toca Pet Doctor</td>
<td>2-6 yrs</td>
<td>$2.99</td>
<td></td>
</tr>
<tr>
<td>Toca Doctor</td>
<td></td>
<td>$2.99</td>
<td></td>
</tr>
<tr>
<td>Doodle Bowl</td>
<td>&gt;3 years</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td>Fruit Ninja</td>
<td>6-18 years</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td>Candy Pizza Maker</td>
<td>4-12 years</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td><strong>Games (Apps)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominos</td>
<td>&gt;7 years</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td>Board Game Collection</td>
<td>&gt;7 years</td>
<td>$2.99</td>
<td></td>
</tr>
<tr>
<td>Uno</td>
<td>&gt;5 years</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td>Trivia Crack</td>
<td>&gt;12 years</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td><strong>Art (Apps)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Swirlicity Lite</td>
<td>All Ages</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td>Crayola</td>
<td>2-12 years</td>
<td>$2.99</td>
<td></td>
</tr>
<tr>
<td>Glow Draw</td>
<td>2-15 years</td>
<td>Free</td>
<td></td>
</tr>
<tr>
<td>Coloring Book for Anti-Stress</td>
<td>&gt;10 years</td>
<td>Free</td>
<td></td>
</tr>
</tbody>
</table>

Continued on Back
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Price</th>
<th>Logo</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Music (Apps or online)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spotify</td>
<td>&gt;1 years</td>
<td>Free</td>
<td><img src="image" alt="Spotify" /></td>
</tr>
<tr>
<td>Has nursery rhymes, big band, current hits, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pandora</td>
<td>&gt;3 years</td>
<td>Free</td>
<td><img src="image" alt="Pandora" /></td>
</tr>
<tr>
<td>Animal Piano</td>
<td>1-7 years</td>
<td>Free</td>
<td><img src="image" alt="Animal Piano" /></td>
</tr>
<tr>
<td>Talking Tom &amp; Ben News</td>
<td>4-12 years</td>
<td>Free with Ads</td>
<td><img src="image" alt="Talking Tom" /></td>
</tr>
<tr>
<td>Ginger 2 (Kitten)</td>
<td></td>
<td>$3.99 no Ads</td>
<td></td>
</tr>
<tr>
<td>Has a “Child Mode”</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Relaxation/Breathing/Imagery</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Various Programs on You Tube</td>
<td>&gt;7 years</td>
<td>Free</td>
<td><img src="image" alt="YouTube" /></td>
</tr>
<tr>
<td>(can be accessed on your phone, ipad or computer)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Settle Your Glitter- App</td>
<td>4-15 years</td>
<td>Free</td>
<td><img src="image" alt="Settle Glitter" /></td>
</tr>
<tr>
<td>Stop, Breathe, Think- App</td>
<td>10-18 years</td>
<td>Free</td>
<td><img src="image" alt="Stop Breathe" /></td>
</tr>
<tr>
<td>Healing Buddies Comfort Kit- App</td>
<td>4-18 years</td>
<td>Free</td>
<td><img src="image" alt="Healing Buddies" /></td>
</tr>
<tr>
<td><strong>Movie Options</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amazon Prime</td>
<td>All Ages</td>
<td>Some Free with your</td>
<td><img src="image" alt="Amazon Prime" /></td>
</tr>
<tr>
<td>Download to your phone- Movies, Cartoons, etc.</td>
<td></td>
<td>membership and some you pay</td>
<td></td>
</tr>
<tr>
<td>Xfinity</td>
<td>All Ages</td>
<td>Some Free with your</td>
<td><img src="image" alt="Xfinity" /></td>
</tr>
<tr>
<td>Download to your phone</td>
<td></td>
<td>membership and others you pay per movie</td>
<td></td>
</tr>
</tbody>
</table>

There are a lot of options! Ask family members who have children in the age group you want to address what they use! Ask the kids themselves! Be sure to consider any streaming or download charges that may apply.  
[http://pami.emergency.med.jax.ufl.edu/](http://pami.emergency.med.jax.ufl.edu/)

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![Distraction Toolbox](image) ![PAMI](image)

**Pain Assessment and Management Initiative**
Exploring Nonpharmacologic, Child Life & Distraction Toolbox Techniques for Pain Management

Toolbox Component Ideas

**Infant**

2. Classic Teethers
3. Musical Toys (Rainmaker, Shaker)
4. Pacifier
5. Sucrose solution (Sweet ease, Tootsweet)

**Toddler**

7. Rubik’s Cubes
9. Bubbles

**Pre-School**

12. Pinwheels

**Grade School**

13. Peaceful Piggy Meditation (Albert Whitman Prairie Books)
   a. By Kerry Lee MacLean
14. Imaginations 2: Relaxation Stories and Guided Imagery for Kids (Volume 2)
   a. By Carolyn Clarke
15. Coloring Book
16. Playskool Crayons
17. Madlibs

**All Ages**

Continued on back
18. **Oball Shaker** [https://www.amazon.com/Kids-II-81107-Oball-Shaker/dp/B008J1QP7Y/ref=sr_1_1_a_it?ie=UTF8&qid=1487874310&sr=8-1&keywords=oball+shaker](https://www.amazon.com/Kids-II-81107-Oball-Shaker/dp/B008J1QP7Y/ref=sr_1_1_a_it?ie=UTF8&qid=1487874310&sr=8-1&keywords=oball+shaker)

19. **Liquid Motion Bubbler** [https://www.amazon.com/Bubbler-Sensory-Children-Activity-Assorted/dp/B00ZY6JHU4/ref=sr_1_3?ie=UTF8&qid=1487874335&sr=8-3&keywords=Liquid+Motion+Bubbler](https://www.amazon.com/Bubbler-Sensory-Children-Activity-Assorted/dp/B00ZY6JHU4/ref=sr_1_3?ie=UTF8&qid=1487874335&sr=8-3&keywords=Liquid+Motion+Bubbler)

20. **Glow Ball**
21. **Funny Face Glasses**
22. **Flashing Stick**
23. **Playing Cards**

27. **Mobile Device (iPad or other tablet)**

**Tool bag:**


![Diamond Drawstring Cinch Backpack](Image)
This resource is a communication tool for hospital, ED, EMS providers and their patients. The cards are designed to assist in communication with children and families, especially non-English-speaking or non-verbal patients.

Materials and designs were created by Nye and Associates Smarter Marketing™ for University of Florida College of Medicine-Jacksonville, Dept. of Emergency Medicine. This tool was adapted from Minnesota Emergency Medical Services for Children (EMSC), Children's Hospitals and Clinics of Minnesota, Kansas EMSC and Kansas Department of Health.

Funding provided by Florida Medical Malpractice Joint Underwriting Association (PECSI & PAMI) and the Children’s Miracle Network Hospitals.
Phone Emergency Contact Number

(_______)

_______ -

_______

Hospital Gown

Bed

Doctor Nurse Examination Stethoscope
**Pain Scale FLACC**

<table>
<thead>
<tr>
<th>FLACC Scale</th>
<th>0</th>
<th>1-2</th>
<th>3-4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face</td>
<td>None or uncooperative or crying</td>
<td>Calm, relaxed or cooperative</td>
<td>Respond to verbal commands, may be crying</td>
</tr>
<tr>
<td>Legs</td>
<td>Relaxed, extended</td>
<td>Inflexible, slightly flexed</td>
<td>Rigid, flexing</td>
</tr>
<tr>
<td>Activity</td>
<td>Normal quiet behavior</td>
<td>Abnormal, alert to pain stimulus</td>
<td>Arched rigid or jerking</td>
</tr>
<tr>
<td>Cry</td>
<td>None</td>
<td>Moans, whimpers, occasional complaints</td>
<td>Steady cry, scream, sobs, frequent complaints</td>
</tr>
</tbody>
</table>

**Pain Scale Faces**

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**Injury Mechanisms**

- Car crash
- Fall
- Knife
- Gunshot
Happy Sad Scared Frightened

Hot Cold Sick Dizzy
Head Hurts
Ear Hurts
Throat Hurts
Cough
Back Hurts
Chest Pain
Stomach Hurts
Throw Up
Use as needed with a dry erasable marker.